

marrow cavity at this point—and applied the ivory clamp. This was removed in five weeks. First attempt at walking in three months. No functional loss.

The ivory does not irritate as it is immobile. Indications: (1.) Compound fractures with rebellious dislocation which cannot be corrected by dressings or extension. (2.) Simple fractures (pseudarthroses) in which mediate retention does not succeed.

Although he was unable to find like published cases, yet Volkmann had informed him of three cases of pseudarthroses in which he had followed a similar plan with success, with the difference that he had allowed the plugs to remain.—*Arch. f. klin. Chirg.*, 1886, Bd. 34, Hft. 2.

WM. BROWNING (Brooklyn).

III. On Some Elements of Success in Excision of the Knee-joint. By W. THORNLEY STOKES, F. R. C. S. T. The author divides the flaps in the middle line as high 'as the synovial pouch extends, in order to thoroughly remove the latter with knife, scissors and spoon.

To avoid oozing after the operation, and consequent early change of dressings, Esmarch's bandage is not to be used, nor any tourniquet.

In order to attain more perfect fixation of femur to tibia, two silver dowels are thrust through the tibia on each side of its tubercle upwards, backwards and outwards into the femur nearly to its popliteal surface; these are withdrawn in two or three weeks.—*Brit. Med. Jour.*, April 2, 1887.

A. F. STREET (Westgate).

IV. A Method of Fixing the Bones in the Operation of Excision of the Knee-joint. By HOWARD MARSH (London). The author remarks that in putting up an excision of the knee, the surgeon has not only to guard against the shifting of the tibia on the femur that may be produced by the movements of a restless patient, by spasmodic action of the muscles, or by the disturbance of the limb

when the patient is lifted, however carefully, for the action of the bowels; he has also to prevent the riding of the femur in front of the tibia, which is especially apt to occur in cases in which the bones of the leg have undergone displacement backwards toward the popliteal space—to prevent the latter condition, he has for the last four or five years employed the apparatus recommended by Mr. Gant, in his *Practice of Surgery*, second edition. This consists of an outside splint and a back splint. The latter is a simple straight splint, extending from just below the tuberosity of the ischium to the commencement of the tendo-Achillis. In adaptation to the limb it is wider above than below, slightly concave and well padded; but in adjusting it pads are added to the part corresponding to the leg, so that the tibia is brought well forward and landed up, so as to be raised to the level of the femur. By this means the plan of binding the femur down to the level of the tibia, a proceeding which involves firm constriction of the thigh, and often produces œdema of the soft parts about the knee, and thus interferes with sound healing is avoided—as soon as the limb has been secured on the back splint, so that the tibia lies in easy and close contact with the femur, the bones are pinned together. Mr. Marsh uses bone pegs—ordinary bone knitting needles answering the purpose well, for these he finds with their ends sharpened, always easily introduced through orifices in the tibia made with a brad-awl, and can be readily driven to the requisite distance onward into the femur by a few slight taps with a mallet—the outside splint reaching as high as the great trochanter, furnished with a foot piece and interrupted at the knee, completes Mr. Gant's apparatus. It seems to steady the whole limb. It is applied as soon as the bone pegs have been introduced. The concluding part of the operation comprises the suturing and dressing of the wound. These steps come last, so that it can be ascertained that, when all is finished, the bones are still in proper apposition, and so that the dressings can be changed without disturbance of either the outside or the posterior splint. The pegs are cut off short at the time of the operation, and do not require further attention. The author has used the bone pins in nine cases, in each of which a very satisfactory result has been obtained. One case was a lad of 16,

who walked a distance of 120 miles, six months after the operation, in seven days.—*Brit. Med. Jour.*, Feb. 19, 1887.

H. PERCY DUNN (London).

IV. Transplantation of Bone for Ununited Fracture.

A. PONCET (Lyons). Patient, aged 19, with ununited fracture of tibia (compound). Thirteen months since accident. Bone transplanted between the fragments was the first phalanx of the great toe of an amputated leg (minus the articular ends).

Antiseptic precautions were taken and the graft soaked in sublimate solution before insertion. The graft lived, but the operation was not successful in securing bony union.—*Lancet*, May 28, p. 1,102.

C. B. KEETLEY (London).

GYNÆCOLOGICAL.

I. On the Frequency of Malignant Growths of the Ovaries and Their Operative Treatment. By Prof. LEOPOLD.

Careful study of the finer structure of these neoplasms during the past fifteen years has demonstrated the fact that their malignant nature is much more frequent than was formerly supposed. Observations on the nature and frequency of these malignant tumors have been made by numerous authors, such as Olshausen, who reported 14 cases of sarcoma in his own practice. Cohn found among 600 ovariectomies of Schroeder 100 cases where the tumors were undeniably malignant or showed malignant degeneration. The tabulated list of these cases shows a percentage of 16.6 for the malignant nature of all ovarian tumors. This is of much importance in regard to the question of desirability of removing such malignant growths. Permanent recovery in such cases was once held to be very questionable and rare. Observations, however, of Schroeder show that 16.6% of his ovariectomies revealed malignant tumors, and that 19.5% of the operated cases of this kind remained free from a return of the disease for more than a year, *i. e.*, recovered. Cohn, therefore, concludes from this, that all proliferating neoplasms of the ovaries, even of both ovaries, should be removed as quickly as possible. If an operation be delayed until all indications, as given by Wells and others, shall have appeared, the